Whereas, states may implement premiums and cost-sharing, including copays, coinsurance, deductibles, and other charges, for Medicaid and CHIP patients, which limits enrollment efforts, removes coverage from patients who cannot afford costs, and raises rates of uninsured patients, uncompensated care, and expensive emergency care\(^1\)–\(^8\); and

Whereas, 8 states use CMS Section 1115 waivers to charge Medicaid premiums, 26 states charge CHIP premiums, and 21 states use other cost-sharing in CHIP\(^6\)–\(^7\); and

Whereas, the RAND Health Insurance Experiment found that increased cost-sharing reduces use of both necessary and unnecessary services at similar rates and worsens health for patients from the most low-income households and patients with the most severe illness\(^8\); and

Whereas, in Indiana, 13,600 patients lost Medicaid, 46,200 patients lost eligibility, and 289,000 patients were restricted benefits due to inability to pay in 2015 and 2016\(^6\)–\(^9\)–\(^11\); and

Whereas, in Arkansas, only 14% of Medicaid patients paid at least one premium in 2015, and in Michigan, only 47% of those owing premiums paid at least one from 2014 to 2021\(^12\)–\(^13\); and

Whereas, in Indiana and Wisconsin, inability to pay locks patients out of Medicaid for 6 months, while in Montana patients are locked out until all premium debt is paid\(^6\); and

Whereas, in Wisconsin, even an increase of up to $10 in monthly Medicaid premiums resulted in a 12% decrease in probability of remaining enrolled\(^14\); and

Whereas, in Alabama, CHIP premium and copay increases decreased renewal by 8%, especially among Black children, low-income children, and children with chronic illness\(^15\); and

Whereas, Medicaid copays affect preventive and chronic care, reducing vaccination rates and increasing rates of uncontrolled hypertension\(^16\)–\(^17\); and

Whereas, state collections from premiums and cost-sharing are extremely limited and do not significantly finance care, comprising less than 0.02% of Michigan’s Medicaid budget\(^6\)–\(^13\); and

Whereas, state premiums and cost-sharing may even increase administrative costs, with Arkansas premiums increasing costs by nearly 30% compared to standard Medicaid\(^12\); and

Whereas, with the end of the COVID public health emergency, states that previously could not disenroll patients from Medicaid due to unaffordable costs may now reimpose those measures, leading to even greater expected coverage losses\(^1\); therefore be it
RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children’s Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-290.982 “Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured” by deletion as follows;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery of financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health
insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (Modify Current HOD Policy)

and be it further

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums to Medicaid beneficiaries. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

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REFERENCES


RELEVANT AMA POLICY

D-290.979 Medicaid Expansion
1. Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.  
2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. [Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Appended: Res. 122, A-22]

H-290.965 Affordable Care Act Medicaid Expansion
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.  
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.  
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.  
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.  
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.  
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.  
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.  
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.  
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.  
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.  
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.  
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.  

H-290.960 Oppose Medicaid Eligibility Lockout
Our AMA will oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods, and support provisions that permit them to reapply immediately for redetermination. [Res. 103, A-18]